**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**SPECIAL TERMS AND CONDITIONS (STCs)**

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| **NUMBER:** | 11-W-00145/8 |
| **TITLE:** | Primary Care Network |
| **AWARDEE:** | Utah Division of Health Care Financing |

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## I. PREFACE

The following are Special Terms and Conditions for the Utah Primary Care Network Medicaid section 1115 demonstration program. The Special Terms and Conditions have been arranged into the following subject areas: General Conditions for Approval, Legislation, Eligibility, Benefits, Cost Sharing, General Financial Requirements, Monitoring Budget Neutrality, and Operational Protocol.

Amendment requests, correspondence, documents, reports, and other materials that are submitted for review or approval shall be directed to the Centers for Medicare & Medicaid Services (CMS) Central Office Project Officer and the Regional Office State Representative at the addresses shown on the award letter.

## II. GENERAL PROGRAM CONDITIONS

1. **Pre-Implementation Requirements.** All Special Terms and Conditions prefaced with an asterisk (*) contain requirements that must be approved by CMS prior to the implementation date for the demonstration. No Federal Financial participation (FFP) will be provided for section 1115 program demonstration eligibles until CMS has approved these requirements. FFP will be available for project development and implementation, compliance with Special Terms and Conditions, the readiness review, etc. Unless otherwise specified where the State is required to obtain CMS approval of a submission, CMS will make every effort to respond to the submission in writing within 45 days of receipt of the submission. The CMS and the State will make every effort to ensure that each submission is approved within 60 days from the date of CMS's receipt of the original submission.

2. **Definitions.** For purposes of the Special Terms and Conditions, the following definitions apply.
    a. "Implementation date" is defined as the first date on which current eligibles have their benefits restricted and are subject to increased cost sharing or enrollment fees, or Demonstration Population I and Demonstration Population II eligibles are eligible to receive Primary Care Network Services, whichever is earlier.
    b. "Current eligibles" is defined as individuals covered under Utah's Medicaid State Plan who are also included in this demonstration. This includes adults age 19 and above eligible through Section 1925 and 1931 of the Social Security Act (the "Act"), including those eligible through any liberalized Section 1931 criteria already in the state plan, and adults age 19 through 64 who are medically needy and not aged, blind, or disabled.
    c. "Demonstration Population I" is defined as individuals age 19 and above with incomes under 150 percent of the federal poverty level who are not otherwise eligible for Medicaid through the state plan, and who are only covered under Medicaid through the section 1115 demonstration.
    d. "Demonstration Population II" is defined as any pregnant women deemed by the state to be high risk, and who meets all other Medicaid eligibility criteria under

SOBRA, and who have assets in excess of the limit established by the state plan.

e. "Mandatory" refers to those eligibility groups that a State must cover in its Medicaid State Plan, as specified in Section 1902(a)(10) and described at 42 CFR Part 435, Subpart B.

f. "Optional" refers to eligibility groups that can be covered under a Medicaid or SCHIP State Plan, i.e., those that do not require a section 1115 demonstration to receive coverage and who have incomes above the mandatory population poverty levels. The Medicaid optional groups are described at 42 CFR Part 435, Subpart C.

3. *** Concurrent Waiver Programs.** The State's three section 1915(b) waivers and its Title XXI State Children's Health Insurance Program will continue to operate concurrently with the section 1115 demonstration. The state shall submit an amendment to its three 1915(b) waivers to remove as an eligible population the current eligibles in the Primary Care Network, and to amend cost effectiveness accordingly. The amendment shall be submitted 60 days prior to the implementation date of this demonstration.

4. **Adequacy of Infrastructure.** The demonstration includes adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing limits; and reporting on financial and other issues.

5. *** Public Notice and Consultation.** Prior to the implementation date, the State will comply with the public notice requirements issued via September 27, 1994 edition of the Federal Register, and the tribal consultation requirements issued via letter by CMS on July 17, 2001. The state shall submit to CMS the results of the tribal consultation 30 days prior to implementation of the demonstration.

6. *** Preparation of Operational Protocol.** Prior to service delivery under this demonstration, the State must prepare and CMS must approve an Operational Protocol document that represents all policies and operating procedures applicable to this demonstration. The required content of the Operational Protocol is outlined in Section VIII of these Special Terms and Conditions.

7. **Extension or Phase-out Plan.** No later than 12 months prior to the expiration of the demonstration, the State must notify CMS whether it plans to request an extension of the demonstration. Requests for extensions will be due no later than one year prior to the expiration of the demonstration. If the State does not intend to request an extension, it must submit to CMS a phase-out plan no later than one year prior to the expiration of the demonstration. The phase-out plan is subject to CMS review and approval.

8. **Enrollment Limitation During the Last Six Months.** If the demonstration has not been extended, no new enrollment is permitted during the last six months of the demonstration.

9. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the

demonstration, the State must fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the demonstration program.

10. **Matching of State-funded programs.** The demonstration increases the amount and scope of publicly funded health care services in the State. The amount of State funds expended for the UMAP program will be maintained or increased above the SFY 2001 level during the operation of the demonstration. The expenditures that would otherwise be made for the state-funded Utah Medical Assistance Program (UMAP) are eligible for federal matching funds through this demonstration. No other current or previous state-funded program is eligible for federal matching funds.

11. **CMS Right to Terminate or Suspend.** The CMS may suspend or terminate this project in whole or in part at any time before the date of expiration, whenever it determines that the State has materially failed to comply with the terms of the project. The CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights under 42 CFR 430, Grants to States for Medical Assistance Programs, to challenge CMS's finding that the State materially failed to comply. The CMS reserves the right to deny pending waiver requests or withdraw waivers at any time if it determines that granting or continuing the waivers would no longer be in the public interest. If the project is terminated or any relevant waivers withdrawn, CMS will be liable for only normal close-out costs.

12. **State Right to Terminate or Suspend.** The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State must promptly notify CMS in writing of the reasons for the suspension or termination, together with the effective date. If the project is terminated or any relevant waivers suspended by the State, CMS will be liable for only normal close-out costs.

## III. GENERAL REPORTING REQUIREMENTS

1. **Quarterly Progress Reports.** No later than 60 days after the end of each quarter, the State must submit progress reports. These reports must include information on operational and policy issues appropriate to the State's program design. It must also include information on the disenrollments of optional current eligibles due to non-payment of enrollment fees (see Section VII, item 5), and member months (see Attachment A, item 3.a). The report must also include proposals for addressing any problems identified in each report. The State must include a discussion of the specific content of these reports in the Operational Protocol (see Section VIII).

2. **Monitoring Calls**. CMS and the State will hold monthly monitoring calls to discuss issues associated with the implementation and operation of the demonstration.

3. **Annual Reports.** The State must submit a draft annual report documenting accomplishments, including project status; quantitative and any case study findings; and policy and administrative difficulties no later than six months after the end of its

operational year. Within 30 days of receipt of comments from CMS, a final annual report will be submitted. The State must include a discussion of the specific content of these reports in Operational Protocol (see Section VIII).

4. **Final Report.** At the end of the demonstration, a draft final report must be submitted to CMS for comments. The CMS's comments shall be taken into consideration by the State for incorporation into the final report. The CMS's document *Author's Guidelines: Grants and Contracts Final Reports* is available to the State upon request. The final report is due no later than 90 days after the termination of the project.

## IV. LEGISLATION

1. **Changes in the Enforcement of Laws, Regulations, and Policy Statements.** All requirements of the Medicaid program expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter of which these Special Terms and Conditions are a part, will apply to the demonstration. To the extent that changes in the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, CMS will incorporate such effects into a modified budget limit for the Demonstration. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement. If the law, regulation, or policy statement cannot be linked specifically with program elements of the demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit will be proportional to the size of the demonstration in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).

2. **Changes in Medicaid Law.** The State must, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the demonstration award date. To the extent that a change in Federal law, which does not exempt State section 1115 demonstrations, would affect State Medicaid spending in the absence of the demonstration, CMS will incorporate such changes into a modified budget limit for the Demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law. If the new law cannot be linked specifically with program elements of the Demonstration (e.g., laws affecting sources of Medicaid funding), the State must submit its methodology for complying with the change in law to CMS for approval. The methodology must be consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law. Should CMS and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration States.

3. **Amending the Demonstration.** The State may submit to CMS a request for an

amendment to the Demonstration program to request exemption from changes in law occurring after the waiver award date. The cost to the Federal government of such an amendment must be offset to ensure that total projected expenditures under a modified Demonstration program do not exceed projected expenditures in the absence of the Demonstration (assuming full compliance with the change in law).

## V. ELIGIBILITY AND ENROLLMENT

1. **Screening for Medicaid**. Applicants for the demonstration will be screened for Medicaid eligibility. Participants will be enrolled in the most beneficial program, in terms of benefit package and cost sharing, for which they are eligible. During the demonstration project, eligibility status of participants will be redetermined on a regular basis. Current eligibles who become pregnant will be screened to determine if they are eligible for the more beneficial SOBRA pregnant women category, and if qualified, will be switched to the SOBRA eligibility category. Should current eligibles disenroll, the State shall screen their dependent children to determine whether they are eligible for other Medicaid eligibility categories, and if found eligible, enrolled.

2. **Expansion statewide**. Any eligibility expansion will be statewide, even if other aspects of the demonstration are being phased-in.

3. **Enrollment limits**. The total enrollment limit for Demonstration Population I eligibles shall be 25,000. The total limit shall have two sub-limits: 9,000 for childless adults, and 16,000 for adults with children. During the demonstration, subsequent changes to the enrollment limit should be submitted as a waiver amendment no later than 90 days prior to the date of implementation of the change(s) for approval by CMS. Within 30 days of receipt of the amendment, CMS will identify, in writing, all significant issues that are to be addressed by the State, and will work with the State toward a final decision within 60 days. The 60-day period does not include the period in which the State is responding to CMS s written comments and questions on the amendment. The state shall describe the process for establishing enrollment limits in the Operational Protocol in Section VIII. No enrollment cap may be applied to current eligibles or to Demonstration Population II eligibles.

## VI. BENEFITS

1. **Minimum for current eligibles.** The benefit package for current eligibles in the demonstration is that detailed in the state's proposal of December 11, 2001, which is reduced from that available under the state plan. Any changes to the benefit package must be submitted as a waiver amendment. The benefit package for current eligibles may not be reduced below the level of one of the benefit packages allowed under Title XXI. The State will monitor and report on the impact of the benefit reduction on current eligibles.

2. **Minimum for Demonstration Population I eligibles.** The benefit package for

Demonstration Population I eligibles in the demonstration is that detailed in the state's proposal of December 11, 2001, which is significantly reduced from that available under the state plan. Any changes to the benefit package must be submitted as a waiver amendment. The benefit package for Demonstration Population I eligibles must be comprehensive enough to be consistent with the goal of increasing the number of individuals in the State with health insurance, including at least a primary care benefit, which means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

3. **Minimum for Demonstration Population II eligibles**. The benefit package for Population II eligibles is that available under the state plan. No benefit reductions implemented through demonstration authority apply to Demonstration II eligibles.

## VII. COST SHARING

1. **Current eligibles.** Cost sharing amounts for current eligibles are those submitted in the state's December 11, 2001 proposal. Any changes must be submitted as a waiver amendment. In all cases, cost sharing amounts for current elgibles must be limited to nominal amounts in accordance with Section 1916 of the Social Security Act and implementing regulations at 42 CFR 447.53-54. In addition, the state must exempt current eligibles from cost sharing for those services and populations identified in 42 CFR 447.53-54.

2. **Demonstration Population I.** Cost sharing amounts for Demonstration Population I eligibles are those submitted in the state's December 11, 2001 proposal. Any changes must be submitted as a waiver amendment.

3. **Exemption for tribal members.** Demonstration Population I eligibles who are tribal members will not be charged copayments, co-insurance, or deductibles when receiving services from the Indian Health Service or Tribal health care systems.

4. **Exemption for Demonstration Population II.** Cost-sharing for Demonstration Population II eligibles is limited to that required under the state plan.

5. **Enrollment fee**. The State may impose an annual enrollment fee of up to $50.00 for optional current eligibles and Demonstration Population I eligibles. Any changes to the enrollment fees shall be submitted as a waiver amendment. The State will monitor and report quarterly per Section III.1 the number of disenrollments of optional current eligibles in the Primary Care Network demonstration due to nonpayment of annual enrollment fees. The State shall monitor and report quarterly per Section III.1 whether any dependent children of optional current eligibles disenrolled due to non-payment of enrollment fees lost Medicaid eligibility. The State shall send samples of all premium notices and any other public notices relating to imposition of premiums, disenrollment for

non-payment of premiums, and beneficiary rights and responsibilities under the premium requirement to CMS for review. No enrollment fee may be imposed on mandatory current eligibles or Demonstration Population II eligibles.

## VIII. OPERATIONAL PROTOCOL

1. *** Prior Approval.** Prior to the implementation date, the State must prepare, and CMS must approve, a single Operational Protocol document representing all policies and operating procedures of the demonstration. The protocol must be submitted to CMS no later than 90 days prior to program implementation. The CMS will respond within 60 days of receipt of the protocol regarding any issues or areas that require clarification. No Federal Financial Participation (FFP) will be provided for Medical Assistance Payments under the demonstration until CMS has approved the Operational Protocol. The State must assure and monitor compliance with the protocol.

2. **Changes to the Operational Protocol.** During the demonstration, subsequent changes to demonstration program and the Operational Protocol that are the result of major changes in policy or operating procedures must be submitted for review by CMS. The State must submit a request to CMS for these changes no later than 90 days prior to the date of implementation of the change(s).

3. **Operational Protocol Content.** At a minimum, the protocol must address all of the following areas, plus any additional features of the demonstration referenced in these Special Terms and Conditions or the State's application for the demonstration:

    a) **Organization and Structural Administration.** A description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration, and the tasks each organizational component will perform. Include details about the organizational components responsible for eligibility, outreach, enrollment, compliance with cost sharing limitations, monitoring, evaluation, and financial management.

    b) **Reporting Items.** A description of the content and frequency of each of reporting items as listed in Section III of this document

    c) **Income Limit.** A detailed discussion of the income limits the State will use for the program.

    d) **Eligibility/Enrollment.** A detailed description of all groups eligible for the demonstration; and the processes for eligibility determination and annual redetermination, enrollment and disenrollment, and procedures for ensuring that all applicants will be screened for and placed in the most beneficial programs for their needs as described in Section V.1. Also describe the State's outreach, marketing, and staff training strategy, including: information that will be communicated to providers, potential demonstration participants, and State

outreach/education/eligibility staff; types of media to be used; specific geographical areas to be targeted; types of locations where such information will be disseminated; and the availability of bilingual materials/interpretation services and services for individuals with special needs. The State should also describe how it will review and approve marketing materials prior to their use.

e) **Enrollment cap.** Discuss the operational details. Please discuss any process for revising the limit and include a description of any procedure for establishing and maintaining waiting lists for participants in the demonstration.

f) **Implementation Schedule.** Please discuss the operational details and provide an implementation schedule.

g) **Benefits.** Describe the benefit packages to be provided to current and Demonstration Population I and Demonstration Population II eligibles, including any limitations or exclusions on covered benefits.

h) **Coverage Vehicles.** Include descriptions of all the health service delivery options that are included in the demonstration, including fee-for-service, Medicaid managed care, employer-sponsored insurance, and other options. Include a discussion of the delivery systems for current eligibles and for Demonstration Population I and Demonstration Population II eligibles.

i) **Cost Sharing.** Provide a discussion of the cost sharing limits and enrollment fees applicable to current and Demonstration Population I and Demonstration Population II eligibles, including:

- cost-sharing and enrollment fee amounts;
- the State's plans to monitor compliance with the cost sharing limits;
- how they will be reported to CMS (refer to item 2 of Attachment A of this document);
- the process through which enrollees and providers will be informed of enrollee financial obligations;
- the grace period, if any, during which enrollees may make the enrollment fee payment without termination from the program;
- how the State will notify the enrollee that he or she has failed to make the required payment and may face termination from the program if the payment is not made;
- how the individual will be assured the right to appeal any adverse actions for failure to pay enrollment fees; and
- the process in place to re-enroll the individual in the demonstration if payment of the required enrollment fee is paid.

j) **Quality.** Describe the State's overall quality assurance monitoring plan. The plan should include, at a minimum, the following: Quality indicators to be

employed to monitor service delivery under the demonstration and the system to be put in place so that feedback from quality monitoring will be incorporated into the program; quality monitoring surveys, and the monitoring and corrective action plans to be triggered by the surveys; and fraud control provisions and monitoring.

**k) Grievances and Appeals.** Provide a description of the grievance and appeal policies that will be in place in the demonstration and how the process will be monitored.

l) **Evaluation Design.** Provide a more detailed description of the State's evaluation design included in its December 11, 2001 proposal, including:

- a discussion of the demonstration hypotheses that will be tested;
- outcome measures that will be included to evaluate the impact of the demonstration;
- what data will be utilized;
- the methods of data collection;
- how the effects of the demonstration will be isolated from those other initiatives occurring in the State; and
- any other information pertinent to the State's evaluative or formative research via the demonstration operations.

**ATTACHMENT A**
**GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX**

**1.** The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide Federal Financial Participation (FFP) for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in Attachment B (Monitoring Budget Neutrality for the demonstration). Federal financial payment will not be provided for expenditures financed by collections in the form of pharmacy rebates, enrollment fees, or third party liability.

**2.** **a.** In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap will be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 2.b.

**b.** For the purpose of this section, the term "expenditures subject to the budget neutrality cap" will include all Medicaid expenditures on behalf of all demonstration participants (i.e. current eligibles, Demonstration Population I, and Demonstration Population II as defined in Section II.2 of the Special Terms and Conditions) that are also receiving the services subject to the budget neutrality cap.

**c.** For each demonstration year a Form CMS-64.9WAIV and/or 64.9PWAIV will be submitted reporting expenditures subject to the budget neutrality cap. All expenditures subject to the budget neutrality ceiling for demonstration eligibles (current and expansion) must be reported. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 2.b.).

**d.** Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration.

**e.** All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

**f.** The procedures related to this reporting process, report contents, and frequency must be discussed by the State in the Operational Protocol (see Section VIII).

**3. a.** For the purpose of calculating the budget neutrality expenditure cap described in Attachment B, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for the Medicaid Eligibility Groups as defined in section 3.c below. This does not include member months for childless adults in the Demonstration I population, nor members of Demonstration Population II. This information should be provided to CMS in conjunction with the quarterly progress report referred to in number 1 of Section III. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the implementation date, or the anniversary of that day.) Procedures for reporting eligible member/months must be defined in the Operational Protocol (see Section VIII).

**b.** The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.

**c.** There will be two demonstration Medicaid eligibility groups (MEG). The first MEG will be "Current Eligibles," and will be comprised of current eligibles as defined in Section II.2.b of the Special Terms and Conditions.

The second MEG will be the hypothetical "1902(r)(2) Eligibles." These are members of the Demonstration Population I as defined in Section II.2.c of the Special Terms and Conditions who could be eligible for Medicaid under Section 1931 if the state further liberalized its eligibility criteria in its state plan. "1902(r)(2) Eligibles" does not include members of Demonstration Population I who are childless adults, nor members of Demonstration Population II.

**4.** The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Medicaid expenditures on the quarterly Form HCFA-37. As a supplement to the Form HCFA-37, the State will provide updated estimates of expenditures

subject to the budget neutrality cap as defined in 2 c. of this Attachment. The CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 annually with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

**5.** CMS will provide Federal Financial Participation (FFP) at the applicable Federal matching rate for the following, subject to the limits described in Attachment B:

**a.** Administrative costs, including those associated with the administration of the demonstration.
**b.** Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State Plan.
**c.** Medical assistance expenditures made under Section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

**6.** The State will certify State/local monies used as matching funds for the Primary Care Network demonstration and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.

**ATTACHMENT B**
**MONITORING BUDGET NEUTRALITY**
**FOR THE DEMONSTRATION**

The following describes the method by which budget neutrality will be assured under the demonstration. The demonstration will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the waiver period. This limit will be determined using a per capita cost method. In this way, the State will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of eligibles. By providing FFP for all eligibles, CMS will not place the State at risk for changing economic conditions. However, by placing the State at risk for the per capita costs of Medicaid eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a demonstration year (DY) basis. The annual estimates will then be added together to obtain an expenditure estimate for the entire demonstration period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 5-year period for the types of Medicaid expenditures described below. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.

**Base Year Expenditures**

The base year expenditure and per capita amounts, and demonstration years trended per capita amounts must be consistent with enforcement of laws and policy statements, including regulations and letters regarding impermissible provider payments, health care related taxes, or other payments; if necessary adjustments must be made. The CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act.

The base year will be state fiscal year 2001. Base year expenditure and enrollment data (calculated in member months) will be used to calculate base year per capita costs for current eligibles under this demonstration. A base year per capita amount will be established for each Medicaid Eligibility Group. The base year expenditure and enrollment data must be finalized with CMS no later than six months from waiver approval.

Budget neutrality agreements may include optional Medicaid populations that could be added under the State Plan but were not included in current expenditures. However the agreement will not permit access to budget neutrality "savings" from the addition of the group. A prospective per capita cap on federal financial risk will be established for this group based on the costs that the population is expected to incur under the waiver. Eligibility groups that are added to the State's program, and incorporated into the demonstration, in response to changes in law or

regulation will be treated similarly, i.e., there will be no access to budget neutrality "savings" from the addition of the group.

Base year expenditures and trended per capita amounts will not be included for Medicaid State Plan amendments submitted after the established base year. All State Plan amendments submitted before or during the base year must be reflected in the base year data finalized with CMS.

**Projecting Service Expenditures**

Each demonstration year estimate of Medicaid service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the State under the guidelines set forth in Attachment A number 3.a. If the Demonstration Years do not align with base year or fall beyond the range of years shown must be calculated by pro-rating the agreed-upon annual trend rate for the appropriate number of months.

The trend rate for each Medicaid Eligibility Group (MEG) for each year of the demonstration are listed below.

| Demonstration Year | Trend Rate by MEG | |
|---|---|---|
| | Current eligibles | 1902(r)(2) |
| 2003 | 8.00% | 8.00% |
| 2004 | 8.00% | 8.00% |
| 2005 | 8.00% | 8.00% |
| 2006 | 8.00% | 8.00% |
| 2007 | 8.00% | 8.00% |

Using the trend rates to produce Demonstration Year PMPM cost estimates
If the beginning and the end of the demonstration do not coincide with the base year, the following methodology will be used to produce DY estimates of PMPM cost. Using a monthly equivalent growth rate, the appropriate number of monthly trend factors will be used to convert base year PMPM costs to PMPM costs for the first DY. After the first DY, the annual trend factor will be used to trend forward from one year to the next.

**How the limit will be applied**
The limit calculated above from the trended service expenditures will apply to actual expenditures for demonstration services, as reported by the State under Attachment A. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for beneficiaries and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be based on the time period through the termination date.

**New Funding**

If the State seeks to reallocate Title XXI or Disproportionate Share Hospital (DSH) funds to fund this demonstration, the state must request a waiver amendment. These funds are only available on a prospective basis. In order to provide for a seamless continuation of 1115 waiver authority for the eligibles under Title XIX, the State should provide CMS with adequate notification of the State's intent.

**Expenditure Review**

CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative target, they must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

| Year | Cumulative target definition | Percentage |
|---|---|---|
| Year 1 | Year 1 budget neutrality cap | +8 percent |
| Year 2 | Years 1 and 2 combined budget neutrality cap | +3 percent |
| Year 3 | Years 1 through 3 combined budget neutrality cap | +1 percent |
| Year 4 | Years 1 through 4 combined budget neutrality cap | +0.5 percent |
| Year 5 | Years 1 through 5 combined budget neutrality cap | 0 percent |